

**Questions and Comments Concerning Mental Health Screening**  
**From the January 19, 2006 Meeting of the**  
**Wisconsin Program Enhancement Plan**  
**Child Welfare Case Process Committee**

**Subject:** MHST 5 Years to Adult Tool

**Comments:**

- Regarding question #4 on Identified Risk Page, this is not culturally sensitive to Native Americans where hearing voices, etc., may be considered a “gift” in spiritual services. This needs to be open for interpretation to be culturally sensitive. Tribal constituents will be consulted.
- Regarding question #5 on Identified Risk Page, the child may need an assessment based on where and when the prior assessment was done, current needs, etc. Also, whether this is an in-home or out-of-home case is a critical issue. Even if it is an in-home, must consider whether we need to help the family get a prescription filled. Suggest adding language or what steps worker should do first (or bypassed) before marking this as “yes” about “consulting with current provider” as an option for the worker. Also, need to know if there has been a gap since taking their prescribed medication. It was also requested that the term “immediate” be defined.
- Regarding question #3 on Identified Risk Page, if this would require an urgent referral, it needs to be changed for a worker to opt out of this if other information suggests otherwise. May need to take this to a supervisor.
- Regarding question #2 on Identified Risk Page, the definitions of “severe” physical abuse, or “extreme” violent behavior must be clear. The word “torture” is a high threshold, “violence” might be more appropriate. This may also be a training issue. Constituents working with domestic violence programs will be consulted.
- Regarding question #7 on Risk Assessment Page, a new assessment may not be needed. We should not forget other steps. This may also be a training issue.
- An adolescent with a current mental health provider may need information, but may not need an assessment.
- The “Identified Risk” page requires an “urgent” referral according to the instructions if a worker saw these things answered “yes”. There is less discretion, as there is the most danger for the child with these items, as opposed to the second page for “Risk Assessment” where there is more discretion. It is important to be clear on the MHST 5 Years to Adult Section I regarding “Identified Risk” vs. Section II on “Risk Assessment”.
- Timeframes such as “90-days” seems arbitrary. Should reconsider placing artificial time constraints in the tool.
- Using the term “Risk Assessment” on page 2 makes it look like we are confusing the terms assessment vs. screening.

**Subject:** General Comments regarding the Proposed Screening Tools and Process

**Comments:**

- It might be useful for workers to have some web-based training or resources for medical information for reference purposes. Examples would be common acronyms and a list of psychotropic medications.
- There may be some confusion in use of the tool due to broad-based use for both in-home and out-of-home care. This could impact on the validity of the tool.
- For the pilots we need to determine what an acceptable error rate is and which kids we want to capture and say these are the kids we do not want to miss.
- The screening tool information can be used with functionality as a baseline to make a good judgment and use as guidance for workers to elicit information. It should be looked at as a piece of the information gathering—not the whole picture; one part of the assessment tool.
- There is a concern regarding the element of liability if a parent does not cooperate and the worker cannot make a referral for an assessment happen. About 90% of cases are closed after assessment. Response is to document the attempt to make the referral. Also a concern if there is no money or no resource to make the referral to.
- Need to tone down some of the language to make the referral for assessment more discretionary. The entire child functioning should be looked at as part of the initial assessment. There needs to be a balance between

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the MHST vs. the analysis of the overall assessment. It is helpful to assist workers, but we do not want to overburden them.

- How can we incorporate language that allows the worker to use other assessments (i.e. the Initial Assessment) and discretion from their general experience and knowledge with the family into the tool?
- The tool's purpose is to identify red flags that may indicate a need for assessment by a mental health professional---it may or may not result in the provision of treatment services.
- The term "licensed mental health professional" includes a broad array of providers, which could include or be part of a county team.
- The responses on the screening may just show a need for consultation. There needs to be clarification for workers on what consists of a referral and when to make the referrals. It could help to work this out through mental health colleagues based on county structure and policies. The pilot counties/tribes should help to sort the specifics out.
- The counties/tribes doing the pilots will need some training, but the pilot will help to develop statewide training curriculum.
- Counties/Tribes with Mental Health Child Advocacy Centers may be good strategy for the pilots.
- Assuming both private and public providers in a pilot county, it is a good idea to bring Health Maintenance Organizations (HMO's) to the table, as for referrals for HMO's it means that the member calls. The HMO's need to be on board.
- One pilot county should just screen the out-of-home care children.
- Will information be going out to County 51 agencies?
- Are there current pilots going on using the GAIN Tool? No. They are using a more comprehensive GAIN Tool, which is part of an initiative to build a capacity network. This screening tool is a short form of the GAIN.
- County/Tribal Child Protective Services (CPS) and mental health folks should look over the tool. If part of the pilot, they should also create a procedure for workers to know where to start when implementing the tool.